Governor's Prevention Advisory Council
Evidence-based Prevention Workgroup
Phase 2 Inquiry Final Report

California's Governor's Prevention Advisory Council Members' Evidence-based Practices: Assessment of Key Practices

February 25, 2010

Modified July 2010

Prepared by Christina Borbely, PhD on behalf of the Center for Applied Research Solutions

Overview

The Community Prevention Initiative was commissioned to examine the nature of evidence-based prevention practices among the 15 GPAC member agencies. In July 2008, Phase 1 concluded with an assessment of use of "evidence-based"[1] standards or criteria policy, programs or services provided or funded by the 15 GPAC member agencies. Given limited response to requests for information, the investigation relied exclusively on information found in the public domain. Findings are recommendations were provided in a summary report and presented at the July 2008 session (Assessment of California's Governor's Prevention Advisory Council's Evidence-based Practices: A Review of Current Status & Recommendations for Next Steps). It was determined by GPAC that additional information should be gathered.

In February 2009, GPAC members interested in evidence-based prevention participated in a conference call discussion to identify potential next steps for a workgroup. The following proposal was designed:

Workgroup proposal:

> *The workgroup will convene and information will be gathered to identify any agency-based "experts" in the agency's applied standards of evidence-based prevention. If such person is identified, he/she will serve as the point of contact for a Phase 2 investigation. The workgroup will conduct a Phase 2 assessment of the extent to which evidence-based prevention plays a role in individual agencies, what role it plays, how it is defined in concept and practice and lessons learned. The workgroup will produce a synthesis of information and specify potential directions for establishing a cross-agency, evidence-based prevention principle..*

The following information reflects the process and outcomes from the Phase 2 assessment. Recommendations are provided.

GPAC member agencies were contacted by email and at subsequent GPAC sessions and encouraged to participate in the Phase 2 Inquiry. Instructions for identifying an appropriate agency "expert" in evidence-based prevention to serve as a point person for communication were provided.

[1] In general, "evidence-based" refers to

> Use of programs or strategies scientifically proven to be effective in achieving desired reductions in or risk of designated behaviors (e.g. ATOD use).

Individuals designated as agency point person were contacted by email and provided an overview of the EBP Workgroup history and objectives. A Point of Interest document was provided and options for providing information were defined (including phone interviews, email interviews or written reports). One phone interview, one email interview and one written report (in two parts) were provided. That is, three agencies contributed information of six who indicated an interest in contributing; no other agencies responded. A summary of responses by Point of Interest area is provided in the addendum.

Phase 2 Findings

Findings are limited by the scarcity of respondents. Three of 15 member agencies contributed information. As a result, it is not possible to generalize findings to the broader GPAC membership. It may be most useful to consider the Phase 2 findings as additional context to determinations made in the Phase 1 report (referenced here for convenience).

A primary focus of the Phase 2 Inquiry was to learn about the extent to which evidence-based prevention plays a role in individual agencies and what role it plays. Two of the three respondents describe a sophisticated, systematic and integrated application of EBP in theory and practice. These agencies develop definitions of EBP as criteria for decision making and prevention service selection.

Phase 1 report

- 3 of 15 members provide explicit definitions or standards of criteria for use of evidence-based programs or practice.
- 5 of 15 (33%) included no reference to or information about “evidence” used to select or define programs or practice.
- Remainder of members (almost 50%) provided information ranging from minimal or insinuated EBP (e.g. practices that were proven to work in other communities were adopted) to somewhat substantiated (e.g. single reference to “research” without explanation).

Another focus of the Phase 2 Inquiry was on the definition of EBP in concept and practice. In two cases, EBP were defined by credentialing agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA). Also noted is the use of research literature to identify effective programs, practices or strategies.

In Phase 1 report

- “[programs] be based on scientifically based research demonstrating that the program to be used will reduce violence and illegal drug use."
- "research materials on innovative youth programs" and "routine evaluations to assess progress, and to refine, improve and strengthen program effectiveness."
- "use of evidence-based programs"

- "training, training standards, and learning objectives recommendations provided in this pamphlet are considered Best Practices as based on published research conducted by experts in the field..."
- "[experts] provide cutting-edge prevention programs, develop crime and violence prevention policies, advocate for proven strategies, offer training in effective prevention strategies…"
- "assessment of effectiveness…use of effective methods."

A final objective of the Phase 2 Inquiry was to garner lessons learned from agencies' successes and challenges related in EBP. There are several noteworthy recommendations to enhance the success and sustainability of EBP, including:

- Flexibility & room for local level innovation
- Willingness of key partners from variety of sectors (law enforcement) to participate in commitment to EBP.
- Reviewing literature and success on {in like agencies} maintains momentum.
- Building it into strategic plan, MOUs, funding mechanisms (i.e. formalize it).
- Presence of EBP champion(s) willing to drive it forward.

This dimension was not part of the Phase 1 Inquiry.

The Phase 2 Inquiry also yielded information that may be helpful in determining future actions for a workgroup.

- There has been a shift toward allowing individual states to determine their own EBPs. This in itself has created difficulty as there is not a clear understanding as to how states are supposed to establish their own list of approved EBPs.

- "Evidence-informed" is defined in our agency as drawing from literature or other sources to determine approach is effective when a model or EBP program is not available.

- The current inconsistency in definition and use of EBP across state agencies is cited as contributing to duplication of AOD prevention efforts. In addition, it is suggested that unified efforts to develop a common standard for EBP might lead to more efficient resolution of ATOD issues and enhance cost effectiveness.

Currently states such as Oregon, Georgia, Ohio, and South Carolina have done the following:

- Issue definitions for terms
- Provide criteria for standards "evidence"
- Recommend guidelines for use of EBP

- Develop tool kits to support use of EBP
- Establish policy for majority of funding only for EBP

Conclusions

The Phase 1 and 2 Inquiry provided a detailed profile of the variable state of EBP in theory and practice across agencies. Though there clear support for the exploration of EBP, it is not clear that there is the capacity for member agencies to fully embrace an initiative to achieve GPAC consensus on EBP issues. There are however, several agencies that may serve as role models for institutionalizing EBP. This creates an opportunity to lead by example or foster increased integration of EBP in other member agencies.

Recommendations:

- Continue to build GPAC member capacity for EBP through resources and trainings.
- Convene a GPAC-populated and GPAC member-led workgroup to draft and propose
  - Use of consistent terminology, inclusive of meaningful definitions, across agencies.
  - Integrate terminology into GPAC agency literature (i.e. public domain)
  - Develop guidelines for agencies addressing California's ATOD issues.

Addendum

GPAC EBP Phase 2 Inquiry Findings: Key Points

	Agency 1	**Agency 2**	**Agency 3**
Point of Interest			
To what extent does evidence-based prevention have a role at your agency?	The role in implementation of primary prevention services is predominately administrative	• Pre/post tests of knowledge with students at Drug Store (not analyzed)	• Most of AOD focus falls within Student Health Services. • Since 2003 the campus has been extensively engaged in implementing EBP as part of CA Safer University Prevention Research Center study.
Does the agency maintain policies that require use of EBP associated with substance use and violence prevention (or promotion of wellbeing) initiatives? How does this manifest?			• Use of EBP is part of participation in CA Safer University study. • It was part of 2005 4-yr strategic plan • Is now a standard of practice (so not even in the new 2009 strategic plan as a focus)
If EBP has no or limited place at your agency, please explain the conditions. For instance, why isn't it a consideration? Did it previously have a role? If so, why has its role changed or diminished?			

	Agency 1	Agency 2	Agency 3
Does the agency rely on an alternative standard of practice or criteria for programs/services? (other than EBP) Please describe.			
If EBP does have a role, what role does it play? How does this manifest? Please describe any relevant processes for achieving integration of EBP or maintaining compliance with the designated role of EBP.		Data-driven, needs-based decisions on populations served	• As part of CA Safer University study, Agency 3 had to select from list of EBP strategies • Using visibility of enforcement at local "hot spots" (off campus house parties)
Who is aware or involved in integrating EBP into agency policy or practice? Is it agency-wide, compartmentalized, or some other format?	Prevention Services at Agency 1. Prevention Staff, Management, and Upper Management are aware and involved with the implementation of EBP.	Collaboration with partners for prevention events and coalitions (Red Ribbon, Drug Store, etc.)	Student Health Services uses EBP as a standard operating procedure. It informs collaboration with other partners like law enforcement and local community.
Does the agency rely on other/additional standards of practice or criterion for prevention programs/services? Please compare and contrast these to the role of EBP in your agency.	• SPF • Current definitions in statute/regulations for the appropriateness of services.	• Agency 2 does not have a standardized or formal policy on prevention programs • Individual MOUs can be established when setting up coalitions, partnerships, etc. • Data-driven needs-based decisions on	"Evidence-informed" means drawing from literature or other sources to determine approach is effective when a model or EBP program is not available.

	Agency 1		Agency 3
		populations served	
Is the role of EBP currently growing/evolving, reducing/diminishing, or maintaining status? Please describe any other circumstances of change or fluctuation (current or anticipated).	• It is currently growing and evolving. • Tied to: funding; outcome database	Discussed, but not systematic tracking	Since 2005, the role of EBP has been evolving. Now at a point where it guides prevention strategies implemented. Previously, the focus was not on determining what "works".
What is the agency's purpose in including EBP in its current role?			To offer strategies that are efficient and effective
Is the current role or status of EBP adequate for the agency's purposes? Is it exceeding expectations?	• There is still more room for growth; • EBP will continue to increase at ADP		
Are agency decision makers familiar with the concept of EBP? At what levels?	Yes, Agency 1's Executive, Upper Management, and Management levels are aware of the concept of EBP.		• Student Health Services has shifted staff to all public health experts who "get" environmental prevention • There is a strong EBP champion as a decision maker.
Are agency decision makers involved in integrating EBP into practice?	Looking at ways to better integrate EBP into the primary prevention field within California		Yes
Are agency stake holders (e.g.	Varying levels of		Varies

	Agency 1	Agency 2	Agency 3
constituents, beneficiaries or recipients of programs, services, etc.) familiar with the concept of EBP?	familiarity		
Do agency stake holders expect an EBP standard?	• Not specifically • Some questions about agency recommendations on fidelity v. adapt of prevention programs		Only as part of CA Safer University project
How does your agency define EBP in concept and practice? Please be as specific as possible.			
What sources of information are used to inform the agency's concept and/or application of EBP?	SAHMSA		• Research literature • Programs/strategies that are considered EBP or effective
Does the agency coordinate with any other State agency with regard to the definition or role of EBP across agencies? Please describe.	No, only via GPAC		
What are the benefits or drawbacks to this?	Drawbacks: duplication of AOD prevention efforts Opportunity: if state departments were united in their efforts to establish EBP standards, or at minimum work towards a common understanding of a		

	Agency 1	Agency 2	Agency 3
	definition and practice of AOD prevention would lead to more efficient resolution of AOD issues and be more cost effective		
What lessons have been learned from agency successes re EBP? What works?	• Flexibility; • Room for local level innovation		• Willingness of key partners from variety of sectors (law enforcement) • Reviewing literature and success on other campuses helps with momentum. • Building it into strategic plan.
What lessons have been learned from agency "failure" re EBP? What are/were the challenges or obstacles? How was the circumstance improved or resolved?	• Fidelity can be both a benefit and a hindrance to EBP • Not categorizing their programs accurately as EBP's • Successful programs which may in fact have evidentiary standings are not considered EBP because they have not gone through the extensive and time consuming process of		• It is tough because there is still a pull from outside sources to provide prevention in ways that is not considered EBP (e.g. booths at events) • EBP is harder to do - especially environmental prevention where there is less control of outcome (policy change), so people are "scared" to so it.

		Agency 2	Agency 3
	being accepted for inclusion on the NREPP list.		
What is limited or lacking in the role or status of EBP in your agency? What are points of confusion or resistance?	Various sources use different criteria, resulting in the limited commonality of what constitutes EBP while EBP is presented as if it has a single meaning		Now that AOD issues have decreased, there is less prioritization on prevention.
What expectations or outcomes are associated with the agency's integration of EBP? To whom (if anyone) is the agency accountable for meeting expectations or achieving outcomes?	• That programmatic success would be more measurable. • Responsibility to report information regarding EBP to the federal funding agencies, SAMHSA and the U.S. Department of Education.		Informally, the Dept of Student Affairs sees data and results of initiatives.